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and referrals and allows ample time to include physical examinations, treatments and patient teaching during an appointment, providing after hours coverage by providing prompt telephone access to a clinical staff member on a 24 hour basis who can respond to health care problems, providing care for pregnant and non-pregnant women, assigning residents or team of residents to provide care for a specific panel of patients, operating at least 40 hours per week, including at least 8 hours during evenings or weekends, and providing a tracking system to document care given to the patient when the patient is sent to an emergency service, hospital or other provider of health care service, assisting the patient with arrangements or making arrangements for off-site services, and monitoring reports and results of off-site services and integrating results into patient records, and which train residents to include health maintenance and disease prevention in their patient care, including instruction in breast examinations, mammograms, blood pressure measurements, skin tests for tuberculosis, immunizations, HIV counseling, smoking cessation and drug abuse counseling, shall be assigned a physician specialty weighting factor of 1.1.

(4) The physician specialities of categorical three-year internal medicine programs other than those identified in subclause (1) of this clause and osteopathic internship shall be assigned a physician specialty weighting factor of 1.0.

(5) The physician specialties and subspecialties not defined in subclauses (1),(2),(3) or (4) of this clause shall be assigned a physician specialty weighting factor of 0.9.

(c) The indirect teaching adjustment percentage for the rate period shall be weighted based on projected medical education statistics for the general hospital as of July 1 for the period and subsequently

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reconciled to the actual allocation of residents and fellows for the period.

(iv) For the period September 1, 1992 through June 30, 1993 and each subsequent period commencing July 1 and ending the following June 30, the indirect teaching adjustment percentage for the following hospitals: Hospital for Joint Diseases Orthopedic Institute, Inc., Hospital for Special Surgery, Manhattan Eye, Ear and Throat Hospital, New York Eye and Ear Infirmary, shall be

$$1.89(((1 + r)^{.405}) - 1)$$

where "r" equals the facility's ratio of residents and fellows per bed as defined in paragraph 1 of this subdivision as of September 4, 1990 as contained in the survey document forwarded by the hospital to the department which was to be forwarded no later than November 1, 1990 and the certified beds for the general hospital as of January 1, 1990 excluding exempt unit beds.

(v) Hospitals shall furnish to the department such reports and information required by the commissioner to assess the cost, quality and health system needs for medical education provided.

(i) Hospital groups. Hospitals other than exempt hospitals shall be assigned to peer groups for purposes of calculating group average reimbursable inpatient operational cost per discharge pursuant to the provisions of subdivision (b) of this section. (1) The following groups shall be used:

(i) academic medical centers;

(ii) major public hospitals;

(iii) Metropolitan New York teaching hospitals other than academic medical centers and major public hospitals that meet the teaching criteria specified in paragraph (2) of this subdivision;

(iv) all other metropolitan New York hospitals;

(v) all other hospitals that meet the teaching criteria specified in paragraph (2) of this subdivision;

(vi) all other hospitals that have 99 or less certified beds. If this peer group contains fewer than five facilities, those facilities contained in this group shall be included in the all other hospital group that has 100 or more certified beds but less than or equal to 300 certified beds determined pursuant to subparagraph (vii) of this paragraph;

(vii) all other hospitals that have 100 or more certified beds but less than or equal to 300 certified beds; and

(viii) all other hospitals that have greater than 300 certified beds. If this peer group contains fewer than five facilities, those facilities contained in this group shall be included in the all other hospital group that has 100 or more certified beds but less than or equal to 300 certified beds determined pursuant to subparagraph (vii) of this paragraph.

(2) For purposes of grouping hospitals pursuant to this section, the following definitions shall apply:

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(i) Academic medical centers shall be Strong Memorial Hospital, University Hospital (at Stonybrook), State University Hospital Upstate Medical Center, University Hospital of Brooklyn, Montefiore Medical Center, Albany Medical Center, Mount Sinai Hospital, New York University Medical Center, Presbyterian Hospital in the City of New York, New York Hospital, Westchester County Medical Center and Erie County Medical Center.

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(ii) Teaching hospitals are those hospitals providing accredited post graduate medical training which are not defined as an academic medical center pursuant to subparagraph (i) of this paragraph and which were designated as teaching institutions for the rate periods 1983 to 1987 or which would meet the criteria for teaching institutions applicable in those years.

(iii) Metropolitan New York hospitals shall mean those hospitals located in the five buroughs of New York City and the counties of Nassau, Suffolk, Westchester and Rockland.

(iv) Major public hospitals shall mean all general operated by the New York City Health and Hospitals Corporation as established by Chapter 1016 of the Laws of 1969, as amended, and all other public general hospitals having annual base year inpatient operating costs in excess of $25 million excluding those major public hospitals that are academic medical centers as identified in subparagraph (i) of this paragraph.

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(j) Wage equalization factor (WEF) and power equalization factor (PEF).

(1) Each hospital's cost shall be adjusted in the development of group prices by a wage equalization factor (WEF) determined pursuant to paragraph (2) of this subdivision and a power equalization factor (PEF) determined pursuant to paragraph (3) of this subdivision to reflect the difference between hospitals in the price of labor and utility costs. The WEFs shall be used to adjust for the level of wage and fringe benefit costs for each hospital relative to its hospital group as defined pursuant to subdivision (i) of this section.

(2) The WEF shall be based on staffing levels of nursing aides, orderlies and attendants, licensed practical nurses, registered nurses, nonsupervisory, including head nurses, patient food service workers, X-ray technicians (licensed or registered), laboratory technologist/technicians, housekeeping aides, attendants and porters, and the hospital's proportion of salaries and fringe benefits costs to total operating costs. The WEF shall be determined as follows:

(i) For each occupation listed above, a statewide average salary shall be calculated by dividing the statewide sum of hospitals' dollars paid by the statewide sum of hospitals' hours paid.

(ii) For each hospital, an actual weighted average salary shall be calculated by dividing the total dollars paid for the occupations listed above by the total hours paid for such occupations.

(iii) For each hospital, a composite weighted average salary shall be calculated by summing the products of the hospital's hours paid for each occupation multiplied by the corresponding statewide average salary for that occupation determined pursuant to subparagraph (i) of this paragraph and dividing the result by the total hours paid for that hospital.

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(iv) An initial WEF shall be calculated for each hospital by dividing the hospital specific composite weighted average salary determined pursuant to subparagraph (iii) of this paragraph by the hospital specific actual weighted average salary determined pursuant to subparagraph (ii) of this paragraph.

(v) A hospital specific fringe benefit roll-up factor shall be calculated by dividing the sum of the hospital salaries and fringe benefits by the sum of the hospital's salaries.

(vi) A statewide average fringe benefit roll-up factor shall be calculated by dividing the statewide sum of salaries and fringe benefits by the statewide sum of salaries.

(vii) The final WEF shall be calculated by dividing the statewide average fringe benefit roll-up factor determined pursuant to subparagraph (vi) of this paragraph by the hospital specific fringe benefit roll-up factor determined pursuant to subparagraph (v) of this paragraph and multiplying the result by the initial WEF calculated pursuant to subparagraph (iv) of this paragraph.

(3) The PEF shall be based on monthly bills calculated by the New York State Department of Public Service for each of the major utility companies. The PEF shall be calculated by dividing each utility's cost per kilowatt hour at the appropriate level of usage (small and medium companies) by the weighted statewide average cost per kilowatt hour. The weighted statewide average shall be calculated by summing the products of each utility company's cost per kilowatt hour[~~s~~] multiplied by the corresponding utility's [~~cost per kilowatt hour and dividing the result by the sum of all utility companies' kilowatt hour~~] percentage share of total hospital electric power expenditures.

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(k) Case Mix Index (CMI). A non-Medicare case mix index shall be calculated for each hospital based upon the hospital's last three months of 1986 and the first nine months of 1987 non-Medicare discharges for each diagnosis related group and the non-Medicare service intensity weights included in section 86-1.62 of this Subpart. An adjustment to the CMI shall be made when a full year of 1987 data becomes available. The index shall be used to develop a case mix neutral average cost per discharge pursuant to the provisions of subdivisions (a) and (b) of this section. Exempt unit and short stay cases and transfers except those transfer cases specifically assigned to DRGs that are identified as transfer DRGs shall be excluded from the calculation of the CMI.

(l) Transfers. Rates of payment to acute care non-exempt facilities for patients that are transferred to another acute care non-exempt facility shall be determined on the basis of a per diem rate for each day of the patient's stay in the transferring facility, with the exceptions noted in paragraphs (1) and (2) of this subdivision. The total payment to the transferring facility shall not exceed the amount that would have been paid if the patient had been discharged. The per diem rate shall be determined by dividing the DRG specific operating cost component determined pursuant to section 86-1.52(a)(1) of this Subpart by the hospital's group arithmetic inlier length of stay for the DRG, multiplying by the transfer adjustment factor of 120 percent, adding budgeted capital costs pursuant to section 86-1.59 of this Subpart, and, lastly,

adding a ~~[primary]~~ health care service[s] allowance of .614 ~~[.23]~~ percent of the hospital's non-Medicare reimbursable inpatient costs for rate year 1994 and .637 percent for rate year 1995 computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58. In transfer cases where the group average arithmetic inlier length of stay for the DRG is equal to one, the transfer adjustment factor shall not be applied.

(1) Transfers among more than two facilities that are not part of a merged facility shall be reimbursed as follows:

(i) the facility which discharges the patient shall receive the full DRG payment.

(ii) all other facilities in which the patient has received care shall receive a per diem rate unless the patient is in a transfer DRG.

(2) A transferring facility shall be paid the full DRG rate for those patients in DRGs specifically identified as transfer DRGs, except for those patients whose stay qualifies as short stay outlier days pursuant to section 86-1.55(a) of this Subpart.

(3) Transfers among acute care non-exempt hospitals or divisions that are part of a merged or consolidated facility shall be reimbursed as if the hospital that first admitted the patient had also discharged the patient.

(4) The discharging facility shall receive the full DRG payment as defined in section 86-1.52 of this Subpart.

(5) Services provided to neonates discharged from a hospital providing neonatal specialty services to a hospital reimbursed under the case payment system for purposes of weight gain shall be reimbursed and assigned to a DRG upon admission or re-admission based on the admission or re-admission weight respectively of the infant.

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